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Please answer all questions on **all** pages, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

CHILD'S NAME _____ Nickname _____
Social Security No. _____ Male Female Birthdate ____/____/____

Full-Time Student? School name & location _____

Stepfather Guardian

FATHER'S NAME _____ Birthdate ____/____/____ Social Security No. _____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip Code _____
Father's Occupation _____ Employer _____ Work Phone _____
Cell Phone _____ Email _____

Married Single Partnered Other

Stepmother Guardian

MOTHER'S NAME _____ Birthdate ____/____/____ Social Security No. _____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip Code _____
Mother's Occupation _____ Employer _____ Work Phone _____
Cell Phone _____ Email _____

Married Single Partnered Other

With whom does this child reside? _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Employee _____	Employee _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Insured Birthdate ____/____/____	Insured Birthdate ____/____/____
Employee's S.S. No. _____	Employee's S.S. No. _____

Person responsible for child's account: _____ Phone No. _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____
Relationship to Patient _____ Cell Phone _____ Email _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Is this your child's first dental visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child been seen by an orthodontist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Dentist's Name? _____	Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last visit: _____	Has your child ever taken antibiotics before dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child feel nervous about having dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child receive fluoride in vitamins, tablets, or water? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child ever been premedicated to reduce dental anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccines current? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child ever had a bad dental experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEALTH HISTORY

Is your child having any pain or discomfort at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child been hospitalized during the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list: _____
Has your child been under the care of a medical doctor during the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child taken any medicine / drugs during the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Name _____	If yes, please list: _____
Address _____ Phone: _____	Please list any serious medical condition(s) that your child has or has had: _____

Please check "Yes or No" to the following conditions:

Y/N <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Heart Disease / Attack / Stroke <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Heart Failure <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Heart Murmur / Rheumatic Fever <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Heart Pacemaker <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Diabetes Type:	Y/N <input type="checkbox"/> Blood Transfusion / Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Bruise Easily/Prolonged Bleeding <input type="checkbox"/> Hemophilia <input type="checkbox"/> Liver Disease / Yellow Jaundice <input type="checkbox"/> Kidney Failure/Disfunction <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Glaucoma <input type="checkbox"/> Chemotherapy / Cancer <input type="checkbox"/> X-ray / Cobalt Treatment	Y/N <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Emphysema / Asthma <input type="checkbox"/> Cough / Tuberculosis (TB) <input type="checkbox"/> MRSA <input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Venereal Disease <input type="checkbox"/> A.I.D.S. / H.I.V. <input type="checkbox"/> Hepatitis: A B C (circle one) <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Leukemia	Y/N <input type="checkbox"/> Artificial Joints (Hip, Knee) <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Fever Blisters / Cold Sores <input type="checkbox"/> Fainting / Dizzy Spells <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Hay Fever / Sinus Trouble <input type="checkbox"/> Allergies / Hives <input type="checkbox"/> Shingles <input type="checkbox"/> Nervousness <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Depression/Bipolar (circle one) <input type="checkbox"/> Drug / Alcohol Addiction
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Is your child allergic to or reacted adversely to any of the following?

- | | | |
|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals / Jewelry |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Local/Dental Anesthetic |

Does your child have allergies to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Kent de Vigne and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature _____ **Date** _____

Medical History Update

(For Office Use Only)

Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____